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Local Mental Health Plan

MEDICAL FEE-FOR-SERVICE INPATIENT HOSPITAL PROVIDER MANUAL

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Welcome

Welcome. This is the Provider Manual for Medi-Cal Fee-For-Service (FFS) acute psychiatric inpatient providers contracting with the Los Angeles County Department of Mental Health (LACDMH). This Provider Manual provides information explaining the processes involved in partnering with the LACDMH for the delivery of quality, cost-effective mental health care.

On January 1, 1995, under a State mandate, LACDMH began implementing Phase I of the Medi-Cal Fee-For-Service Inpatient Services. The Phase I Consolidation resulted in significant changes to the delivery of, and reimbursement for, inpatient mental health services provided by Medi-Cal FFS acute psychiatric inpatient providers to Medi-Cal eligible beneficiaries of Los Angeles County. Information regarding the Medi-Cal Fee-For-Service inpatient reimbursement authorization procedures for Los Angeles County are described in this manual.

Thank you for your interest and, if appropriate, participation in the Medi-Cal FFS Consolidation of acute psychiatric inpatient services in Los Angeles County. If you have any questions, requests or comments regarding this manual please contact the LACDMH's Treatment Authorization Unit at (213) 739-7300.

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SECTION: I INTRODUCTION

INTRODUCTION

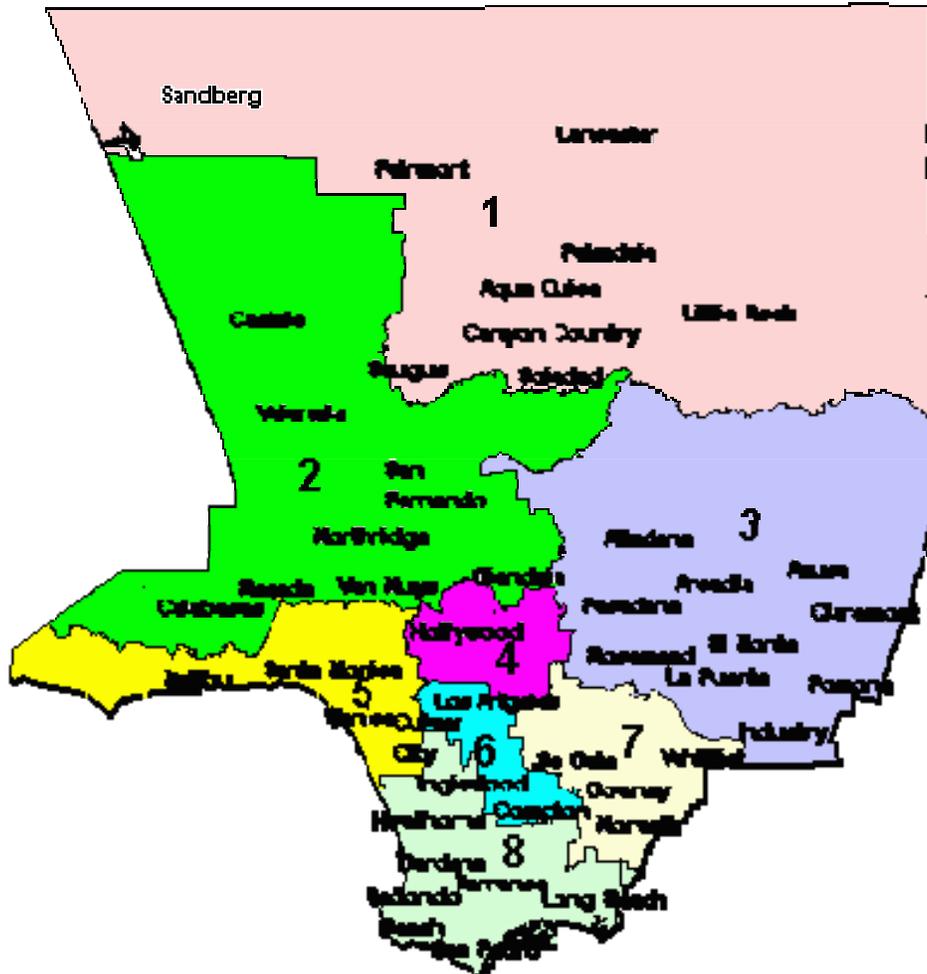
The Los Angeles County Department of Mental Health (LACDMH) is the State of California's Local Mental Health Plan (LMHP) for the County of Los Angeles. The LMHP is responsible for administering all Medicaid/Medi-Cal and State grant funds for mental health services through a well-managed system that is designed to ensure available, accessible, and quality mental health care for eligible Medi-Cal beneficiaries.

It is estimated that Los Angeles County is the county of residency to approximately one-third (1/3) of all Medi-Cal beneficiaries in the State of California. The county where Medi-Cal beneficiary eligibility is established is determined by the Department of Public Social Services. Due to the magnitude of acute psychiatric inpatient services provided to the residents of Los Angeles County, the State of California Department of Mental Health approved the process of retrospective reviews of requests for authorizing reimbursement for Medi-Cal acute psychiatric inpatient services provided to Medi-Cal eligible beneficiaries of Los Angeles County.

The Treatment Authorization Request Unit, within the LACDMH's Office of the Medical Director (OMD), is the program responsible for implementing and operating the State managed care plan, i.e., Inpatient Psychiatric Hospital Consolidation Plan. Under the State's managed care plan, the LMHP is responsible for authorizing reimbursement for Medi-Cal acute inpatient psychiatric services provided to Los Angeles County Medi-Cal beneficiaries. As noted earlier, information regarding the Medi-Cal Fee-For-Service inpatient reimbursement authorization procedures for Los Angeles County is described in this manual.

LACDMH Service Areas

The Los Angeles County Department of Mental Health is organized into eight (8) geographic Service Areas. To identify mental health providers in your service area, go to <http://dmh.lacounty.gov/> Click Services, Click Provider and Contractor Information, and Click for an interactive map with service providers by service area.



SECTION: II LACDMH CONTRACT

Contracting with the County

State of California certified Medi-Cal FFS acute psychiatric inpatient facilities located within Los Angeles County are encouraged to contract with the *County of Los Angeles Department of Mental Health* (LACDMH). Although it is not essential to contract with DMH to be reimbursed for Medi-Cal acute psychiatric inpatient mental health services, contracting promotes a seamless system of care for Medi-Cal beneficiaries residing in Los Angeles County.

This manual, and all subsequent Provider Alerts, provides specific information regarding the requirements and process for contracting with LACDMH and instructions concerning requesting reimbursement for Medi-Cal FFS Acute Psychiatric inpatient services.

Contracting Process

- Obtain from and submit a completed Los Angeles County Department of Mental Health Medi-Cal FFS Acute Psychiatric Inpatient Contract Package to, the LACDMH *Contracts Development and Administration Division* (CDAD).
- Submit a signed contract, completed Contract Package and required documents for approval/adoption by the Los Angeles County Board of Supervisors. Contingent upon the requisite approvals, contract providers will receive a fully executed contract agreement.
- Schedule orientation and training for contract providers to facilitate integration and incorporation of the contract provider into the Los Angeles County Department of Mental Health (LACDMH) system of care.

Contract Required Notifications

It is essential that contract providers immediately inform the LACDMH's Contracts Development Administration Division (CDAD) of the following:

- Any/all changes affecting the provider's ability to provide contracted services
- Changes in ownership
- Mergers
- Financial viability
- Insurance
- Permits
- Licenses
- Staffing Pattern
- Other dated material and changes that are required from the contract package

Failure to formally inform, in writing, the LACDMH's Contracts Development Administration Division (CDAD), in a timely manner, of any/all conditions affecting the contract provider's ability to provide services may constitute a material breach of contract. Contract providers must submit all official correspondence and notices to the following:

**LACDMH Contract Officer
DMH Contracts Development Administrative Division
550 S. Vermont Ave. 5th floor, Room 500
Los Angeles, CA 90020**

SECTION: III SINGLE POINT OF CONTACT

Single Point of Contact (SPOC)

All Fee-For-Service (FFS) Medi-Cal acute psychiatric inpatient providers/hospitals submitting inpatient Treatment Authorization Requests (TARs) to the Los Angeles County Department of Mental Health must designate a Single Point of Contact (SPOC). The SPOC is the person authorized by the provider to discuss or obtain any/all information concerning a specific TAR and/or Medi-Cal beneficiary.

This restriction on accessing information applies only to information regarding a specific Medi-Cal beneficiary to ensure compliance with laws and regulations concerning patient confidentiality. Access is not restricted regarding Medi-Cal information only if unrelated to a specific Medi-Cal beneficiary.

All official correspondence addressed to the TAR Unit must be submitted by the provider's designated SPOC and will be acted upon only if submitted in writing to the TAR Unit for matters such as, but not limited to, the following:

- TAR Inquiry, Corrections and Resubmissions
- Compliance Unit
- First Level Appeal
- Second Level Appeal

Change of Single Point of Contact (SPOC)

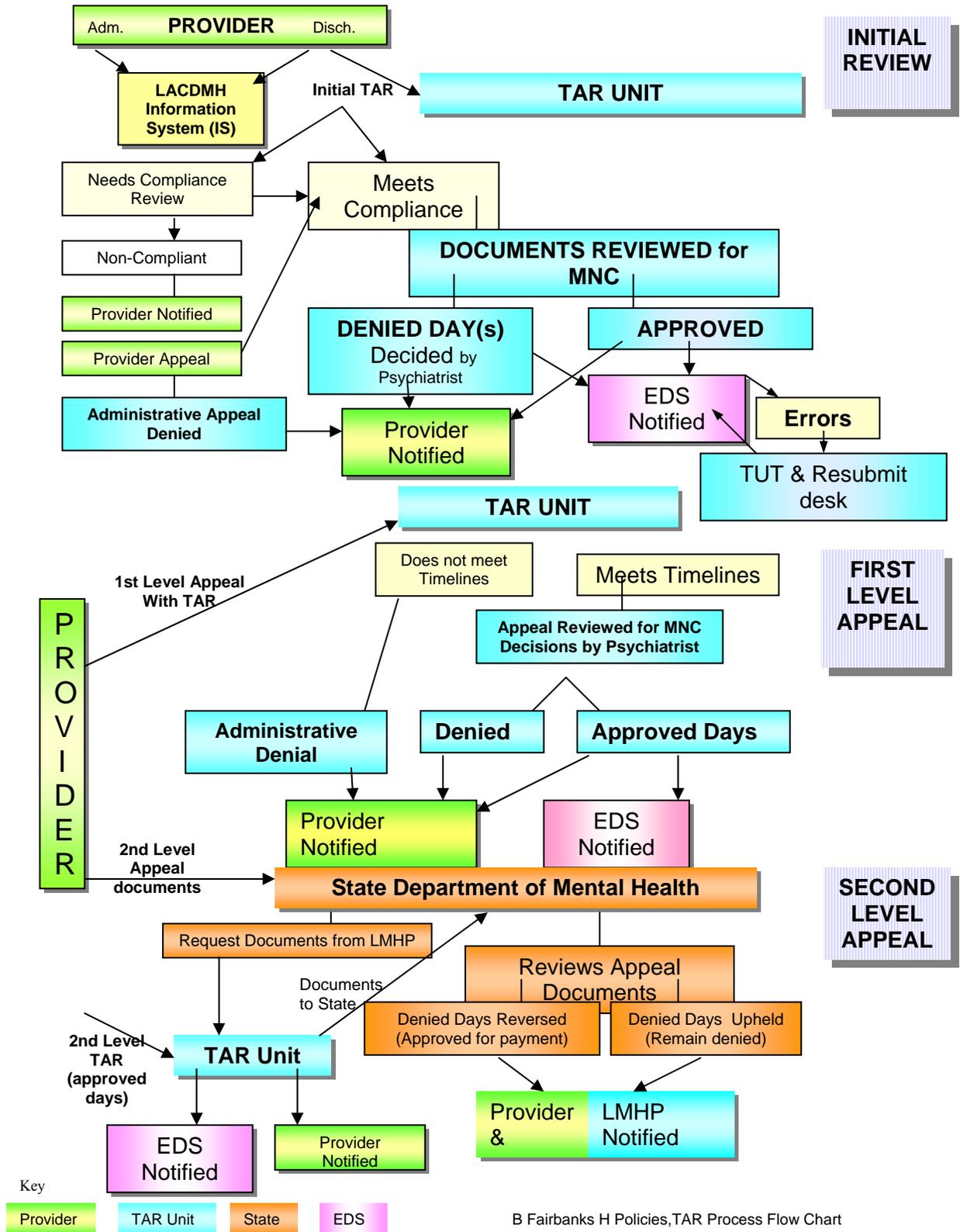
Providers may change their designated SPOC at any time by notifying the TAR Unit in writing, on the provider's letterhead, with the full name, mailing address, email address, telephone number and fax number of the new SPOC.

Provider Alerts

The TAR Unit will issue LACDMH Provider Alerts to contract providers via the SPOC to disseminate information regarding clinical, administrative or financial policies and procedures. Any changes described in the provider Alerts have the authority of policy and are binding to the LACDMH provider's contract agreement with DMH.

SECTION: IV TAR PROCESS FLOW CHART

TAR PROCESS FLOW CHART



KEY TO TAR PROCESS FLOW CHART

TAR: Treatment Authorization Request. A TAR is a State Form (18-3), each with a unique number, used statewide for authorization of inpatient psychiatric hospital days.

PROVIDER: Hospital providing acute inpatient psychiatric services.

IS: *Integrated System* – the LAC/DMH Information System (IS). Charts not entered in the Information System (IS) cannot be processed in the DMH TAR Unit's unique electronic data collection system, previously known as STAR.

- Contract providers have access to the LAC/DMH Information System (IS) and are responsible for entering data on their clients into the system.
- Since *non-contract providers* cannot access the Information System (IS), the TAR unit staff enters the episode data into the Information System (IS) when the TAR & chart arrive to be reviewed.

COMPLIANCE: Compliance with 1) State timeline regulations and/or 2) County contract agreements as specified below.

- **State:** 14-day timeline for submission of an initial TAR or 60-day timeline (from date of discovery of Medi-Cal eligibility) for submission of a *retroactive* TAR.
- **County contract:** Specified data to be entered into the Data Collection and Reporting System.

MNC: Medical Necessity Criteria as specified in State regulations – Title 9, Chapter 11 of the California Welfare and Institutions Code.

LMHP/TAR UNIT: Local Mental Health Plan is the term used by the State to refer to the counties or other entities responsible for authorization of payment for Medi-Cal psychiatric inpatient services. In this instance LMHP is LACDMH and referred to in the chart as the *TAR Unit*.

APPEALS: The provider sends a letter requesting a first or second level appeal of TARs denied for failure to meet MNC or State timelines. *Note: At the second level, chart documents are sent to the State with the appeal letter but not a new TAR. A State decision letter is sent to the provider. If the State reverses denied days (approves those days), the provider submits a TAR, with a copy of the State letter, to the TAR Unit.*

EDS: Electronic Data Systems in Sacramento, CA acts as the State's financial intermediary. This agency is contracted by the State to process payment of the approved days. Payment can only be issued for those TARs in the EDS Master File. *Note: The initial review TAR is always sent to EDS (approved days and denied days) – this establishes the episode in EDS. However, first and second level appeal TARs are only sent to EDS if there are approved days. Approved days, on appeal, are previously denied days that have been reversed by the LMHP or the State.*

SECTION: V TIMELINES

Timelines for Initial Submission of a TAR

Provider has
14 days after discharge
to submit TAR & documents
to the LMHP



LMHP has **14 days** after
receipt of the TAR
to send the reviewed and completed
TAR to EDS and the provider

Timelines for a Retroactive TAR

- Submit a retroactive TAR within
60 days of:
- Discovery of Medi-Cal eligibility
or from a third party Payer -
 - Notice of Partial Payment or
 - Exhaustion of Benefits (EOB)

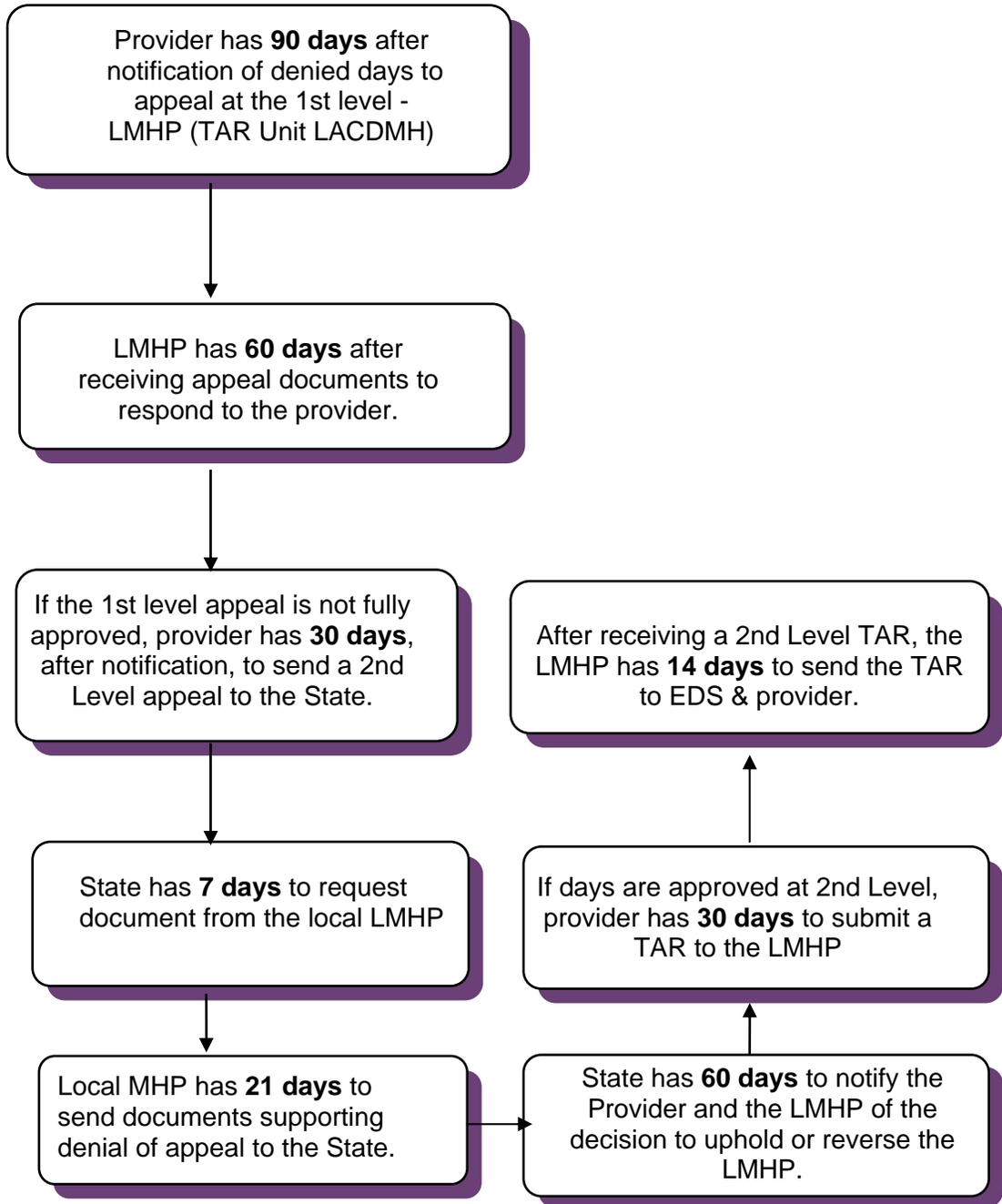
TAR APPEAL TIMELINES

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SECTION: VI INSTRUCTIONS FOR COMPLETING A TAR

INSTRUCTIONS FOR COMPLETING A TAR

The following section is to be completed by the hospital provider

HOSPITAL USE:

Box 6 –Leave blank

Box 7 - Date of admission

Box 8 – Leave blank

Box 9 -Place an “X” on all TARs

Box 10 - Provider NPI number

Verbal Control – Leave Blank

Provider Phone No., Name and Address – 9 digit zip code.

Box 11 – Patient’s Social Security Number or Medi-Cal ID number.

Above Box #11, place the Medi-Cal County Code and Aid Code numbers

Box 12 - Blank

Box 13 - M or F

Box 14 - Date of Birth MM/DD/YYYY and Age (check accuracy with DOB).

Box 15 - Medicare Status: 0 = No Medicare 1= Medicare, Part A only

2 = Medicare, Part B only 3 = Medicare, Part A & B

Box 16 - Other Coverage. “X” if patient has other insurance.

Box 17 - Number of days requested on this TAR.

- The day of admission is counted but **not** the discharge day.
- If other insurance has been billed, include only the Medi-Cal billable days.
- The maximum number of days is limited to 99 days per TAR.

Box 18 -Type of days: “0” – acute. “2” – administrative.

Box 19 -Enter an “**X**” ONLY if the TAR is being submitted as a **Retro TAR**/ If not, leave blank

Box 20 - Date of discharge.

Box 21 - Admitting diagnostic code. It must match the written diagnosis.

Box 22 - Discharge diagnostic code. It must match the written diagnosis

Patient’s Authorized Representative – If known, enter the name and address of the patient’s authorized legal representative, payee or conservator - parent’s name if patient is a minor.

Describe Current Condition Requiring Hospitalization – Complete this section as instructed on the TAR. Use this space to indicate specific dates requested when submitting multiple TARs, Admin Day TARs and Appeal TARs

Planned Procedures – Complete as instructed. On Appeal TARs, leave this section blank.

Signature of Provider & Date: To be signed and dated by hospital representative.

Signature of Physician & Date: Signed and dated by the attending physician or psychologist who has admitting privileges.

For County Use Only: Do not write in this section.

Sample Mental Health Stay in a Hospital TAR form (SDMH 18-3)

To Order: Providers can request TAR forms from Electronic Data Systems' (EDS), by contacting its Medi-Cal Telephone Service Center at (800) 541-5555.

REQUEST FOR MENTAL HEALTH STAY IN HOSPITAL F.I. USE ONLY

COUNTY USE ONLY

COUNTY OF CALIFORNIA
DEPARTMENT OF
MENTAL HEALTH
SERVICES

1. CLAIMS CONTROL NUMBER F.I. USE ONLY

2 3
4 5

CONFIDENTIAL PATIENT INFORMATION
County Code and Aid Code go here

HOSPITAL USE

ADMIT TAR NUMBER (ORIGINAL AUTHORIZATION NUMBER) 6
ADMIT DATE 7 AUTH. EXP. 8 EMER. ADMIT 9

PROVIDER NUMBER 10 PROVIDER PHONE NO. 11 VERBAL CONTROL 12

PROVIDER NAME 13
PROVIDER STREET/MAILING ADDRESS 14
PROVIDER CITY, STATE AND ZIP CODE 15

PATIENT MED-CAL ID NO. 16
PATIENT NAME 17
NUMBER OF DAYS REQUESTED 18 TYPE OF REQUEST 19 NO. IN ACTIVE 20 DISCHARGE DATE 21
ADMITTING DIAGNOSIS DESCRIPTION 22

13 PEND 14 SEX 15 DATE OF BIRTH 16 AGE 17 MEDICARE STATUS 18 OTHER COV.

FOR PHYSICIAN: PLEASE PROVIDE SUFFICIENT ESSENTIAL DETAIL TO PERMIT A REASONABLE EVALUATION OF THE LENGTH AND LEVEL OF CARE REQUESTED.

CURRENT DIAGNOSIS 23 PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY), ENTER NAME AND ADDRESS 24

DESCRIBE CURRENT CONDITION REQUIRING HOSPITALIZATION 25

WHAT PLANNED PROCEDURES WILL REQUIRE THIS HOSPITALIZATION, INCLUDE DATES WHEN POSSIBLE 26

HOSPITAL: TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT 27

SIGNATURE OF PROVIDER 28 DATE 29

COUNTY MEDICAL CONSULTANT-VALIDATING INFORMATION AND EXPLANATION 30

TYPE OF PRINT NAME OF RESPONSIBLE PHYSICIAN 31 SIGNATURE OF RESPONSIBLE PHYSICIAN 32 DATE 33

FOR COUNTY USE ONLY

34 DENIED 35 APPROVED AS REQUESTED 36 FROM 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

SEND TO COUNTY MENTAL HEALTH DEPT. - F.I. COPY

18-3 (11/84)

SECTION: VII SUBMISSION OF A TAR

SUBMISSION OF A TAR

A request for Medi-Cal psychiatric inpatient mental health reimbursement must be submitted on an **original** State Department of Mental Health (SDMH form 18-3 form). That form is commonly referred to as the TAR. Providers can order TAR forms by calling SDMH's fiscal intermediary – Electronic Data Systems (EDS) at (800) 541-5555.

LACDMH conducts **retrospective reviews**. A TAR is to be submitted only after a Medi-Cal beneficiary is discharged from the hospital. When the authorization review is complete, the provider and EDS will be notified of the decision within 14 days following the date of the TAR submission to the LMHP.

Authorization of Medi-Cal reimbursement is conditional on the following:

- The beneficiary was Medi-Cal eligible for Los Angeles County during the month(s) of service.
- The service was provided by a State approved FFS Medi-Cal inpatient provider.
- A timely submission of a *Treatment Authorization Request* (TAR) with an accompanying documentation of Medical Necessity Criteria (MNC). See timeline flow chart.
- Contract providers have entered the episode data into the LACDMH Information System.

Determine Medi-Cal Eligibility

- **Verify Medi-Cal eligibility (POS, AVES or Eligibility Response).**
 - Submit proof of eligibility with the TAR.
 - Write the County and Aid Codes on the TAR, above box #11.
- Submit a TAR only if the beneficiary is eligible for L.A. County (#19) Medi-Cal during the month(s) of service.
- When there is other coverage (Medicare/private insurance) in addition to Medi-Cal, the other coverage must be billed first.
- If Medi-Cal billable days remain after receipt of a partial payment or *Notice of Exhaustion of Benefits* (EOB) from Medi-Care or other insurance carrier, submit a TAR. Please see the following section on *Submission of a Retroactive TAR*.

Los Angeles County Department of Mental Health Information System

All contract providers must enter patient episode data into the LACDMH Data Collection and Reporting System according to established policies and procedures.

Enter the following data:

- Within 24 hours of admission, enter the episode information.
- Prior to submission of a TAR, enter:
 - Discharge information, including date of discharge and
 - Discharge diagnosis.
- Print the *episode screen* showing the correct admitting and discharge dates. Submit this printout with the TAR and chart documents as well as the open episode and closed episode forms.

Note: If there is no recorded **Medi-Cal** eligibility or pending eligibility, do not enter data into the LACDMH Information System (IS).

AFTERCARE PLAN

The Los Angeles County Department of Mental Health (LACDMH) continues to develop quality assurance efforts to ensure comprehensive quality of care services for plan beneficiaries. Continuity of care is essential for the successful transition of a beneficiary from inpatient hospitalization to a lower level of care. In conjunction with the discharge of a Medi-Cal beneficiary, the in-patient provider must prepare a written aftercare plan to be submitted to the appropriate LACDMH Single Fixed Point of Responsibility. A copy of the aftercare plan must also be included with the TAR documents.

INITIAL TAR

Within 14 days from the date of discharge, submit the following:

A) Original TAR – (see Instructions for completing TAR form 18-3)

- 1) **If requesting both acute and admin days**, submit separate TARs.
 - (a) Code box #18 with an ‘0’ for *acute days* and a ‘2’ for *admin days*.
 - (b) Request the correct number of days (box #17) for each TAR.
 - (c) Specify which dates are being requested (in *Current Condition* section).

Note: The *admission* and *discharge* dates will be the same for all TARs in an episode. See *Administrative Day TAR*.
- 2) The maximum number of days that can be requested on a TAR is 99. When the days in an episode reach 100, a second TAR must be submitted. See #1c above.
- 3) **A TAR must be correct and complete in order to be processed.** Check the TAR for missing or incorrect data (e.g. number of days requested, admit and discharge dates, type of days, DSM-IV codes, and signatures and dates).
- 4) When **multiple TARs** are submitted, number the TARs (e.g. 1 of 3 etc.) in the space to the right of the heading *Confidential Patient Information*.

B) Aftercare Plan, with the TAR (but not stapled to it), shall include the following:

- 1) Date & time of follow-up appointment (or reason why one could not be scheduled).
- 2) Name of contact person.
- 3) Name of facilities where the Aftercare Plan was faxed.

C) Proof of Medi-Cal eligibility. – POS, AVES or Eligibility Response

D) Print-out of the LACDMH data system *Episode Screen*.

E) Chart documents/notes to support:

- 1) Medical necessity criteria for *acute days* requested.
- 2) Placement activity for *administrative days* requested.

Submit TARs and documents to:

**TAR Unit
LAC Department of Mental Health
550 S. Vermont Avenue, 7th Floor, Room 701
Los Angeles, CA 90020**

RETROACTIVE TAR

A retroactive TAR may be submitted for the following reasons:

- 1) In case of a natural disaster or circumstances beyond the control of the provider, which has been reported to an appropriate law enforcement or fire agency. (See Title 9, Chapter 11, 1820.215).
- 2) Medi-Cal eligibility inquiry during hospital stay shows *no eligibility*. The finding may be: *No matching records found*. Print inquiry
- 3) Denial of payment (exhaustion of benefits) or a partial payment from a third party payer (Medi-Care or other insurance).

TARs that meet retroactive criteria must be submitted within 60 days of the following:

- 1) **Date of discovery of Medi-Cal eligibility.**
- 2) **Date Remittance Advice Statement (RA) showing partial payment or Notice of Exhaustion of Benefits (EOB) was received from third party.**

Please note: TARs are to be submitted only after having billed any other insurance carrier including Medicare. This includes those situations where it is apparent that some days will have to be billed to Medi-Cal.

Submission of a retroactive TAR:

- 1) Enter the episode into the LACDMH data system.
- 2) Mark box 19 with an "X" to indicate retroactive status.
- 3) Submit either (a) or (b) with the TAR:
 - (a) Proof of Medi-Cal eligibility
 - (b) A copy of the RA or EOB.
- 4) Follow instructions for *Submitting a TAR for Payment Authorization*.

Note: The run date on the proof of eligibility or date stamp on the RA or EOB (reflecting date of receipt) will determine the start of the 60-day timeline for submission of a retroactive TAR.

Please note: TARs will not meet retroactive criteria if at any time during the hospital stay (including the day of discharge) there is discovery of Medi-Cal eligibility or discovery that third party benefits expired or did not exist. If this is the case, these TARs are not to be treated as retroactive.

- 1) Enter the episode in the LAC data system immediately upon discovery of Medi-Cal eligibility.
- 2) Submit the TAR within 14 days after the patient is discharged.

ADMINISTRATIVE DAY

“Administrative Day Services” means psychiatric inpatient hospital services provided to a beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the beneficiary’s stay at the hospital must be continued beyond the beneficiary’s need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options at non-acute residential treatment facilities that meet the needs of the beneficiary.

GENERAL GUIDELINES

- ◆ Request for payment authorization for administrative day services shall be approved by Los Angeles County TAR Unit (TAR Unit) staff when the following conditions are met in addition to requirements for timelines of notification and any mandatory requirements of the contract negotiated between the hospital and the County:
 - (A) During the hospital stay, a beneficiary has met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services.
 - (B) There is no appropriate, non-acute residential treatment facility in a reasonable geographic area.
 - (C) For beneficiaries also eligible under Medicare (Part A) who have received acute psychiatric inpatient hospital services which were approved for Medicare (Part A) coverage.
 - a) Note: (a) Interrupted psychiatric inpatient stay, such as a temporary transfer to another facility or hospital department for treatment of a medical condition and upon return, also meets the administrative day criteria if the psychiatric inpatient stay includes an approved acute day.
 - b) While on administrative day status, a beneficiary’s condition changes to an acute level of care, a modification of the level of care is required. A beneficiary’s stay in the hospital may continue under an administrative day status if after the acute phase, a need for appropriate placement option continues to be established.

- **Administrative Day Documentation Requirements**

Label the medical record entry to identify it as a note documenting discharge planning and/or placement activity (e.g. “Discharge Planning, “Social Services”, ”Administrative Day”). For discharge planning purposes, the reason why administrative days are being sought must be documented in the medical record.

The hospital shall document contacts with a minimum of five appropriate, non-acute residential treatment facilities per week. The requirement of five contacts per week may be waived if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one contact per week.

Note: The reason why there are fewer than five appropriate non-acute residential treatment facilities available for the beneficiary as placement option shall be documented.

- The Los Angeles County Department of Mental Health (LAC DMH) Countywide Resource Management Program (CRMP), informally referred to as the “Gatekeeper Program” functions as bed control for Institutions of Mental Disease and sub-acute mental health facilities. LAC DMH was granted an exemption by the State of California Department of Mental Health from the requirements under CCR, Title 9, Chapter 11, Section 1820.220(j)(B)(5)(A)(B) if the hospital refers the beneficiary for consideration under the discharge process administered by the CRMP and the CRMP accepts the beneficiary for placement consideration under the process. In addition to the contact documentation requirements identified below, the hospital discharge planner shall follow the following procedures when referring beneficiaries to the CRMP:

1. Documentation in the medical record by the hospital staff of the hospital’s referral to the CRMP that is initiated within twenty four hours of an administrative day order identifying the need of a long-term care facility.
2. Submission of any information on the beneficiary’s status to the CRMP by the hospital.
3. An evaluation of the beneficiary by the CRMP that will assign the beneficiary to the CRMP waiting list if admission criteria are met or notify the hospital that assignment to the waiting list has been denied.
4. For beneficiaries who are assigned CRMP waiting list status, documentation by the hospital in the beneficiary’s medical record of the results of the hospital’s weekly contacts with the CRMP that include information on bed availability and waiting list status as reported to the hospital by the CRMP, name of the person contacted and signature of the hospital staff making the contact.
5. When the beneficiary is at the top of the waiting list, notification by the CRMP to the hospital that placement has been authorized and the facilities to which the hospital may refer the beneficiary. The hospital staff shall continue to contact the identified facilities a minimum of every seven calendar days until the patient is discharged.
6. Reasonable promptness by the hospital in discharging the beneficiary to the facility that will be accepting the beneficiary.

Consistent with the exemption stated above, when the CRMP determines that the beneficiary referred by the hospital does not meet CRMP admission criteria, the TAR Unit shall:

- a. Approve the hospital's TAR for administrative days from the date of the administrative day order that placement in an appropriate non-acute residential treatment facility was medically necessary for the beneficiary through the date that the CRMP notified the hospital that the beneficiary did not meet the criteria for admission to the CRMP. It shall be noted that the hospital follow the requirement that a referral be made to the CRMP within twenty four hours of the administrative day order.
 - b. After the date of the denial notification, the TAR Unit staff shall require that the hospital comply with the provisions of CCR, Title 9, Chapter 11, Section 1820.220(j)(B)(5)(A)(B)1.2.a.b.c. as a condition of continued authorization of administrative days.
- ◆ Contact requirements shall be documented to include but not limited to:
- a. Date of the contact.
 - b. Name of the person and facility contacted.
 - c. Facility response regarding availability of beds (status).
 - d. Signature of the person making the contact.
 - e. For IMD placement status prior to CRMP's placement approval, date of the contact (on a weekly basis), name of CRMP staff contacted, number of client on the waiting list status and the signature of the person making the contact must be included in the documentation.

Note: For the hospital's documentation of the facility's response to bed availability, statements such as "pending", "received fax", "reviewing packets", "contacting Public Guardian" are not acceptable. There must be a follow-up documentation of the outcome of the facility's review of the packet within the identified week or 7-day period. The "week" starts on the date that administrative days was ordered.

● **Administrative Day Restriction**

- 1) Before any administrative day can be authorized, there must be at least one approved acute day. (See general guidelines above)
- 2) Medi-Cal Fee-For-Service hospitals – For a Regional Center beneficiary, there is a limit of 4 administrative days per episode.
- 3) Los Angeles County Department of Health Project – limit 5 administrative days per hospital stay.
- 4) Only board and care facilities offering an array of treatment modalities can be considered as placement option billable to SD/MC administrative day services. These augmented board and care facilities fall under the category of Community Residential Treatment System (CRTS) and provide rehabilitative specialty mental health services.

- **Administrative Days for Regional Center Beneficiaries**

- Pursuant to a Memorandum of Understanding (MOU) between the State's Local Mental Health Plan (LMHP) and six (6) Regional Centers (Lanterman, Westside, South Central, San Gabriel, North Los Angeles, and East Los Angeles) located within Los Angeles County, the LMHP will be financially responsible only for the acute psychiatric inpatient days approved and the first four (4) approved administrative days for each acute psychiatric inpatient episode.
- The respective Regional Center will be financially responsible for all subsequent administrative days for their beneficiaries. Upon admission of a Regional Center Medical beneficiary to inpatient psychiatric services, the hospital is required to contact the appropriate local Regional Center to begin placement efforts and to obtain a written pre-authorization for any prospective reimbursement for administrative days.
- The Regional Center pre-authorization applies only to payment for administrative days in excess of the first four (4) approved days covered by the MOU.
- The hospital will also submit a written reimbursement claim/bill for administrative days to the respective Regional Center starting with day five (5).
- The TAR Unit will not authorize reimbursement for any administrative days when the beneficiary is a client of Los Angeles County Harbor Regional Center. This center elected not to be a party to the MOU and subsequent Addendums.

References:

CCR, Title 9, Chapter 11, Section 1810.202; 1820.220(j)(B)(5)(A)(B)

CFR, Title 42, Part 456 Subpart D, §456.235(b)

LACDMH, Countywide Resource Management Program, Intake Procedure for IMD or IMD

Step-down Referrals

Title 9, Article 3.5 Community Residential Treatment System

SECTION: VIII

APPEALS

FIRST LEVEL APPEAL

Guidelines for First Level Appeal

A First Level Appeal may be submitted to LACDMH TAR Unit when requested days on the Initial Review TAR are denied. Information in this section applies to appeals based on medical necessity criteria (MNC) only. Appeals pertaining to timeline denials are to be submitted to the Compliance Unit, (see Compliance Section II).

TIMELINE

- All appeal documents must be submitted within 90 days of the initial TAR denial notification date. This is the date the initial TAR was faxed to the provider. See Appeal Timeline Flow Chart. (Section V).

SUBMIT THE FOLLOWING:

- **An Appeal letter**
 - To justify MNC, send a letter signed by the treating physician addressing the medical necessity criteria for each day being appealed. This letter can be in narrative form or it can be a summary. It may refer to other documentation in the chart (e.g., nurses' notes) but must definitively support the medical necessity criteria as outlined by the State Department of Mental Health.
- **The appeal documents can also include:**
 - Chart pages which were missing from the chart sent for initial review
 - Clarification of illegible notes. Print or type the exact notes before resubmitting.
 - Chart pages on which the missing patient identification has been added.
- **A copy of the initial TAR containing the denied days.**
- **A new TAR for the days being appealed.**
 - This expedites processing an approved appeal TAR.
 - This TAR should have the same admission and discharge dates as the initial TAR. In box 17, indicate the number of acute or administrative days being appealed. In box 18, indicate the type of day, using "0" for acute days and "2" for administrative days. List the actual dates being appealed in the "*Describe Current Condition*" section of the TAR.
IMPORTANT: If the appealed days are not consecutive (e.g., days appealed are: 8/4 & 8/5, and 8/9 & 8/10, a new TAR will be needed for each group of days being appealed). In the example given, two new TARs would be needed. The TAR (18-3) is designed for a request of consecutive days only.

Please Note: It is not necessary to send another copy of the chart with the first level appeal. All charts with denied days remain on file at LACDMH.

- **Change in level of care.** At the filing of the first-level appeal with the Los Angeles County Department of Mental Health, the provider has the option of requesting a change in the level of care. Days which were requested as acute days initially may be appealed as administrative days and conversely, administrative days may be appealed as acute days. In both cases, the corresponding criteria must be met for the days requested. However, this level of care is binding – no change will be accepted at Second Level Appeal.
- **Reminder:** If there were no acute days approved on initial review, at least one of the appealed days must be requested as an acute day. One approved acute day is required before administrative days can be approved. Should both *acute* and *admin* days be appealed, a TAR for each type of day must be sent

Send appeal documents to:

TAR Unit /Appeals Section
Los Angeles Department of Mental Health
550 S. Vermont Avenue, 7th Floor, Room 701
Los Angeles, CA 90020

INQUIRY

The TAR Unit has 60 days to respond to a first level appeal. If the provider has not received a decision within the 60-day time period, we recommend that the provider immediately send an inquiry to determine the status of the appeal including whether or not it was received. This inquiry could be sent as early as 30 days after the first-level appeal was sent, as frequently the appeals are completed significantly earlier than the 60 days allowed. It is crucial to inquire about the appeal as soon as possible after the TAR Unit's 60-day timeline ends because that date starts the 30 day timeline for the provider to appeal to the State. (see Chapter 11, Section 1850.305 (3) (e) (2)).

SECOND LEVEL APPEAL

Appeals to the State must be sent within 30 days after notification of the 1st level appeal decision. See the flow chart for appeal timelines.

State address to submit 2nd Level Appeals:

**Department of Mental Health
Medi-Cal Oversight
1600 9th Street, Room 410
Sacramento, CA 95814
Attn: Bobbie Chevis
TAR 2nd Level Appeals**

State contact for 2nd Level Inquiries:

**2nd Level TAR Appeals
Phone: (916) 651-3838
Fax: (916) 651-3921**

SECTION: IX COMPLIANCE

COMPLIANCE

Inpatient Treatment Authorization Requests (TARs) submitted for Medi-Cal payment authorization must be in compliance with State regulatory timelines as well as State instructions for completing the TAR (State form 18-3-07). Incomplete or incorrect TARs cannot be processed for reimbursement authorization. TARs not meeting State timelines will be denied authorization for hospital payment.

1) TAR Error (provider correction needed)

Incomplete TARs include the following:

- a. Missing physician or provider signature and/or date.
- b. Incomplete or incorrect information in the TAR fields.
- c. Discrepancy between dates of service and days requested.
Note: the day of discharge is not counted.
- d. Incomplete or incorrect diagnostic code.

Provider will be notified of the error by a *Regular Return Letter*.

Provider Response

- a. Corrections are to be made by the provider.
- b. Return all documents to the TAR Unit Compliance Section of LACDMH within 30 days.

After all corrections have been completed the TAR and chart will be processed for payment authorization review.

2) Inappropriate Submission of TAR

- a. Medi-Cal eligibility not with LA County.
- b. Patient remains hospitalized (not discharged).
- c. Duplicate TAR (TAR for this episode previously submitted to LACDMH).

These TARs and documents will be returned to the inpatient provider.

3) State Regulatory Timeline Compliance

1. Timeline Criteria:

- a. The State 14-day timeline not met for Initial Review. Documents must be sent to the LMHP within 14 days of discharge.
- b. The State 60-day timeline for retroactive TAR not met. The 60-day timeline starts with discovery of Medi-Cal eligibility, or notification from Medicare or other insurance carrier of partial payment and/or exhaustion of benefits.

2. Timeline Denial

- a. Authorization for payment to the hospital is denied when State timelines are not met.
- b. A denial letter, for failure to meet State Timelines, will be sent to the provider from the Compliance Section of the TAR Unit.

3. Appeal for Timeline Denial

- a. Within 90 days, the provider can appeal the *State Timeline* denial.
- b. Submit an explanation for failure to meet State timelines and provide documents to verify the reason for lateness (e.g. proof of mailing within the timelines and/or courier records.)
- c. If it is a retroactive TAR, include notification from other insurance carriers. A retroactive TAR requires proof of Medi-Cal eligibility and/or Medi-Cal remittance statements including dates of discovery. (See *RETROACTIVE TAR*.)

Send the timeline appeal to:

TAR Unit
Attention: Compliance Section
Los Angeles County Department of Mental Health
550 South Vermont Ave., 7th Floor
Los Angeles, CA 90020

Note: All correspondence from the TAR Unit to inpatient providers will be sent to the providers' designated Single Point of Contact (SPOC).

CLAIMS OVER ONE YEAR OLD

Per: UB-92 Submission and Timeliness Instruction – Pg 2 .

EDS reviews all original claims delayed over one year from the month of service due to court decisions, fair hearing decisions, county administrative errors in determining recipient's eligibility, reversal of decisions on appealed TARs, Medicare/other health coverage delays or other circumstances beyond the provider's control. Claims submitted more than 12 months from the month of service must always use late billing code "X8".

These claims must be submitted to the following special address:

EDS Over-one-year Claims Unit
P.O. Box 13029
Sacramento, CA 95813-4029

Note: When appropriate the LACDMH TAR Unit will validate circumstances resulting in late claims.

SECTION: X INQUIRY, TUT, AND RESUBMIT

INQUIRY, TUT AND RESUBMIT

All requests regarding TARs, including inquiries, resubmissions or TAR Update Transmittal (TUTs), must be submitted in writing and mailed or faxed to the TAR Unit Inquiry Desk. Always include a copy of the TAR(s) in question.

Send to the Inquiry, Correction and Resubmit desk any of the following requests:

- Status of a TAR
- Requests for a TAR Update Transmittal (TUT). TUTs are used to correct errors on TARs already on the EDS Master File.
- Requests for resubmission of a TAR to EDS

Requests must be as follows:

- Written on hospital letterhead
- Submitted by the Single Point of Contact (SPOC)
- Include the patient's name, dates of service and the 6-digit TAR number.
- **Attach a copy of the TAR in question.**

When requesting a TUT to correct for errors on the EDS TAR Master File, clearly state the correction to be made and include the *box number* on the TAR (e.g. "Correct box # 24 from 12-3-01 to 12-3-00" or "Correct the spelling of beneficiary's name and provide the correct spelling of the name").

A response from LACDMH TAR Unit can be expected within four weeks of receipt.

MAIL TO: Treatment Authorization Unit
Attention: TAR Inquiry, Correction and Resubmit Desk
Los Angeles County Department of Mental Health
550 South Vermont Ave., 7th Floor
Los Angeles, CA 90020

FAX TO: Treatment Authorization Unit
Attention: TAR Inquiry, Correction and Resubmit Desk
(213) 739-0128, 487-7483 or 427-6164

All requests for a TUT or a Resubmit of a TAR must be submitted to EDS by the Local Mental Health Plan (LMHP). Documents are sent to EDS via FedEx and copies of these documents are faxed to the provider.

SECTION: XI MEDICAL NECESSITY CRITERIA

TITLE 9, CALIFORNIA CODE OF REGULATIONS

CHAPTER 11. Medi-Cal Specialty Mental Health Services

1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.

- (a) For Medi-Cal reimbursement for an admission to a hospital for psychiatric inpatient hospital services, the beneficiary shall meet medical necessity criteria set forth in (1) and (2) below:
- (1) One of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:
- (A) Pervasive Developmental Disorders
 - (B) Disruptive Behavior and Attention Deficit Disorders
 - (C) Feeding and Eating Disorders of Infancy or Early Childhood
 - (D) Tic Disorders
 - (E) Elimination Disorders
 - (F) Other Disorders of Infancy, Childhood, or Adolescence
 - (G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
 - (H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
 - (I) Schizophrenia and Other Psychotic Disorders
 - (J) Mood Disorders
 - (K) Anxiety Disorders
 - (L) Somatoform Disorders
 - (M) Dissociative Disorders
 - (N) Eating Disorders
 - (O) Intermittent Explosive Disorder
 - (P) Pyromania
 - (Q) Adjustment Disorders
 - (R) Personality Disorders
- (2) A beneficiary must have both (A) and (B)
- (A) Cannot be safely treated at a lower level of care; and
 - (B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either 1 or 2 below:
 - 1. Has symptoms or behaviors due to a mental disorder that (one of the following):
 - a. Represent a current danger to self or others, or significant property destruction.

- b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.
 - c. Present a severe risk to the beneficiary's physical health.
 - d. Represent a recent, significant deterioration in ability to function.
 2. Require admission for one of the following:
 - a. Further psychiatric evaluation.
 - b. Medication treatment.
 - c. Other treatment that can reasonably be provided only if the patient is hospitalized.
- (b) Continued stay services in a psychiatric inpatient hospital shall only be reimbursed when a beneficiary experiences one of the following:
 - (1) Continued presence of indications which meet the medical necessity criteria as specified in (a).
 - (2) Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.
 - (3) Presence of new indications which meet medical necessity criteria specified in (a).
 - (4) Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a psychiatric inpatient hospital.

LACDMH Review of Medical Necessity Criteria (MNC)

The Medi-Cal Fee for Service Acute Mental Health Inpatient Consolidation Program defines reimbursable acute inpatient psychiatric services in Title 9, California Code of Regulations (CCR), Chapter 11, Section 1820.205. To qualify as reimbursable, each day of service must be appropriately provided and adequately documented when provided to a Medi-Cal beneficiary who, as a result of mental illness is a danger to himself, others, gravely disabled and inappropriate to treat at a lower level of care.

The TAR Unit functions to review psychiatric inpatient provider requests for Medi-Cal reimbursement by determining whether such criteria have been satisfied by the documentation submitted with the TAR.

The basic issue is whether or not hospitalization is required for each day of the hospital stay or whether less restrictive care would suffice. Medi-Cal will only pay for inpatient care when the necessity for that level of care is documented in the chart. There is also a specific listing of diagnoses qualifying for payment.

Specifically excluded are mental states that are the direct effect of a medical illness.

The Los Angeles County Department of Mental Health conducts a retrospective review of requests for Medi-Cal reimbursement for acute psychiatric hospitalizations. We do not provide pre-admission nor concurrent authorizations.

Charts sent to LACDMH TAR Unit are initially assigned on a random basis for review by our review staff. No staff reviewer is assigned to a specific provider or group of providers. Reviewers examine a chart to determine whether, for each day of hospitalization, documentation exists to justify inpatient care per State regulations (Title IX CCR Chap. 11, Sect 1820.205). Reviewers do not interpret documentation, choice of therapeutic modality, efficiency of treatment or even the optimal nature of inpatient care. They only determine documentation of medical necessity. State regulations, Title IX CCR, Chapter 11, stipulate that while approval of an application for payment may be rendered by a licensed mental health professional other than a physician, a decision to reject a request for payment, in part or whole, must be made by a psychiatric physician.

State Medi-Cal Policy Statement 1-89 issued April 12, 1994

Medi-Cal statutes and regulations give the Department of Health Services authority to examine medical records to assure the level of care requested for reimbursement is substantiated. A patient undergoing acute care is expected to need the supervision of a physician each day she/he is hospitalized.

The Medi-Cal program policy regarding coverage of inpatient services is to require documentation of the medical necessity for acute level of care for each 24-hour day authorized. By definition, acute hospital services, including specific physician services, function 24 hours per day, 7 days per week, in order to meet the medical needs of the patients. Physician observation of the patient's status, along with the physician's intervention based on this observation, analysis of the medical record documentation, and interaction with the rest of the health care team is essential in order that appropriate and necessary care will be provided to the patient and to assure the earliest appropriate discharge. This does not mean that the attending physician must visit the patient every day, but when he/she is not available, it is reasonable to assume that a house staff physician, a consultant, or one covering the attending physician's service will assess the acuteness of the patient's status and document his/her assessment.

The question of the need for acute hospitalization on a day when the patient's psychiatrist elects not to see the patient is multi-factorial. It should be noted that authorization for reimbursement is not based solely on the physician's visit. The patient's symptoms are also taken into consideration, as well as any interventions rendered that would necessitate an acute level of care. For mental illness cases where the hospital bylaws permit an attending psychologist, his/her daily visits with documentation of the patient's condition are acceptable to assist in determination of medical necessity of acute care. Visits by any other non-physician practitioners with staff privileges should be documented as well.

SECTION: XII

NOTICE OF

ACTION

TAR DENIAL – NOTICE OF ACTION (NOA-C)

In the event inpatient TAR reimbursement is denied, entirely or partially, both the Medi-Cal beneficiary and the provider requesting reimbursement will be notified of such denial via a timely Notice of Action-C (NOA-C). The NOA-C will provide information regarding the State-mandated procedures for appealing the decision to deny reimbursement.

A *Notice of Action* is a required document that is given to Medi-Cal beneficiaries informing them of denials, terminations, reductions or modifications of requested mental health services from the LMHP and their right to appeal (See document at end of this section). The Notice of Action begins the ninety (90) day period that beneficiaries have to file for State Fair Hearings regarding the decisions indicated on the *Notice of Action*.

The Notice of Action-C issuance is the responsibility of the LMHP

LMHP will do the following:

1. Send the original NOA-C to the beneficiary at his/her last known mailing address as noted in the service provider's documents accompanying the Treatment Authorization Request.
2. Send a copy of the NOA-C to the service provider requesting reimbursement for the inpatient acute psychiatric services.
3. Send a copy of the NOA-C to: Los Angeles County
Department of Mental Health
Patients Rights Unit
4. Retain a copy of the NOA-C

**Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION
(Post-Service Denial of Payment)**

Date: _____

To: _____, Medi-Cal Number _____

The mental health plan _____ County has denied _____ changed your Provider's request
for _____ Los Angeles _____ for
payment of the following service(s):

The request was made by: (Provider name) _____

The original request from your Provider was _____ and your Provider says that you received
dated _____ the
service on the following date or
dates: _____

**THIS IS NOT A BILL. YOU WILL NOT HAVE TO PAY FOR THE SERVICE OR
SERVICES DESCRIBED ON THIS FORM.**

The mental health plan took action based on information from your Provider for the reason check below:

- Your mental health condition as described to us by your Provider did not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205).
- Your mental health condition as described to us by your Provider did not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205): _____
- The service provided is not covered by the mental health plan (Title 9, CCR, Section 1810.345).
- The mental health plan requested additional information from your Provider that the plan needs to approve payment of the service you received. To date, the information has not been received.
- Other

If you don't agree with the plan's decision, you may:

You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at (213) 738-4949 or write to: Patients' Rights Office, Los Angeles County – Department of Mental Health, 550 S. Vermont Ave., Los Angeles, CA 90020 or follow the directions in the information brochure the mental health plan has given to you. You must file an appeal within 90 days of the date of this notice.

If you are unhappy with the outcome of your appeal, you may request a state hearing. The other side of this notice explains how to request a hearing. The state hearing will decide if the plan should pay your Provider for the service that you already received. Whatever the appeal or state hearing decision, you will not have to pay for the service.

NOA-C Post-Service (revised 6-1-05)

YOUR HEARING RIGHTS

You only have 90 days to ask for a hearing. The 90 days started:

- 1. the day after we personally gave you this notice; **OR**
- 2. the day after the postmark date of this notice, **OR**
- 3. if you have filed a grievance, 90 days after the postmark date of a decision denying your grievance.

To Keep Your Same Services While You Wait for A Hearing

- You must ask for a hearing within 10 days from the date this notice was mailed or personally given to you or before the effective date of the change, whichever is later.
- Your Medi-Cal mental health services will stay the same until your hearing or until your provider says you no longer need the services, whichever happens first.

State Regulations Available

State regulations, including those covering state hearings, are available at your local county welfare office.

To Get Help

You may get free legal help at your local legal aid office or other groups. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:

Call toll free: 1-800-952-5253
 If you are deaf and use TDD, call 1-800-952-8349

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself.

Grievance

You may also ask about your hearing rights and your rights to file a grievance with the mental health plan at the number on the front side of this form. If you file a grievance with the mental health plan and are unhappy with the result of the grievance, you will have 90 days to request a state hearing. The 90 days begins after the date the mental health plan sends you its decision on the grievance.

Information Practices Act Notice (California Civil Code Section 1798, et. seq.) The information you are asked to write in on this form is needed to process your hearing request.

Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the mental health plan, the State Departments of Health Services and Mental Health and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2)

DMH NOA-BACK (7-3-98)

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then, send this page to:

State Hearings Division
 California Department of Social Services
 P.O. Box 944243, Mail Station 19-37
 Sacramento, CA 94244-2430

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

HEARING REQUEST

I want a hearing because of a Medi-Cal related action by the Mental Health Plan of _____ County.

Here's why: _____

Check here and add a page if you need more space.

My name: (print) _____

My Social Security Number: _____

My Address:(print) _____

My phone number: (_____) _____

My signature: _____

Date: _____

I need an interpreter at no cost to me. My language or dialect is: _____

I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name _____

Address _____

Phone number _____

SECTION: XIII RESOURCE INFORMATION

Contact Information

- ACCESS Center, telephone number (800) 854-7771, is for public information regarding mental health services throughout Los Angeles County. ACCESS is available 24 hrs, 7-days, including holidays, and is capable of answering calls in languages such as English, Spanish, Mandarin (Chinese), and other languages available from translators.
- California State Department of Mental Health:
Medi-Cal Mental Health Branch
1600 9th Street
Sacramento, CA 95814
Phone: (916) 651-9370
Fax: (916) 654-5591
- Los Angeles County Department of Mental Health Contract Development and Administration Division (CDAD):
Chief, CDAD
550 S. Vermont Avenue, 5th Floor
Los Angeles, California 90020
Phone: (213) 738-4684
- Treatment Authorization Unit:
550 S. Vermont Avenue, Room 701
Los Angeles, California 90020
Tel: (213) 739-7300
Fax: (213) 487-7483/ (213) 427-6164
Email: TAR_Unit@dmh.lacounty.gov
- California State Department of Mental Health's fiscal intermediary, EDS's Medi-Cal Telephone Service Center for requesting Mental Health Stay in a Hospital TAR forms (SDMH 18-3) is (800) 541-5555.
- California State Department of Mental Health's website for Medi-Cal provider enrollment information and application forms is as follows: www.medi-cal.ca.gov

- 1st Level TAR Appeals:
 - 1st Level Appeal Section of the TAR Unit
550 S. Vermont Avenue, Room 701
Los Angeles, CA 90020
Fax # (213) 487-7483 or (213) 427-6164
Telephone # (213) 739-7300 or (213) 639-6344.

- 2nd Level TAR Appeals:
 - 2nd Level TAR Appeals
Phone: (916) 651-3838
FAX: (916) 651-3921

SECTION: XIV PROVIDER SITE REVIEW

PROVIDER SITE REVIEW

The *Local Mental Health Plan* requires that each Contract provider maintains:

- ◆ Compliance with the contract between the provider and the DMH.
- ◆ A safe facility, and when applicable, store and dispense medications in compliance with state and federal laws and regulations.
- ◆ Compliance with documentation standards, maintenance of records, and ability standards as required by the DMH.

The services of providers will be reviewed on a regular basis to determine compliance with various regulatory standards.

SECTION: XV REPORTING ADVERSE OUTCOMES

REPORTING ADVERSE OUTCOMES

All contracted providers must report adverse outcomes to the LACDMH. Such adverse outcomes include any event which threatens or causes actual damage to the health, welfare and/or safety of beneficiaries, staff or the community, including but not limited to, the following:

- Death (unknown cause, suspected or known medical cause or suspected or known suicide);
- Suicide attempt requiring emergency medical treatment;
- Client sustained intentional injury requiring emergency medical treatment;
- Injury to others caused by a client and requiring emergency medical treatment;
- Homicide by a client;
- Alleged client abuse;
- Adverse medication events including medication errors; and
- Possible malpractice.

Upon determining that an adverse outcome has occurred, inpatient contractors must submit an Adverse Outcome Report to the Lanterman Petris Short (LPS) Designation Coordinator, and include the incident(s) in the **MONTHLY DATA REPORT FOR LAC DMH LPS DESIGNATION**.

Reporting of adverse outcomes must be called in immediately to the LPS Designation Coordinator at **(213) 639-6315** during normal business hours, or the ACCESS Center at (800) 854-7771 after hours.

ALL Adverse Outcome Reports should be sent within 72 hours of the occurrence of an adverse outcome to:

LPS Designation Coordinator
Office of the Medical Director
County of Los Angeles Department of Mental Health
550 South Vermont Avenue, 6th Floor
Los Angeles, CA 90020

FAX, as well as send within **24 hours** of the adverse outcome, all Adverse Outcome reports containing time-sensitive information to:

LPS Designation Coordinator
Office of the Medical Director
FAX (213) 738-4646

Before the Adverse Outcome Report is faxed, a telephone call shall be made to the Office of the Medical Director notifying the secretary that the material will be transmitted.

Questions regarding mental health inpatient adverse outcome issues should be directed to the LACDMH LPS Designation Coordinator, 10th floor by telephone at (213) 639-6315 or email at mczubiak@dmh.lacounty.gov.

SECTION: XVI
Integrated System
(IS) / DATA
COLLECTION &
REPORTING
SYSTEM
REQUIREMENTS

DATA COLLECTION & REPORTING REQUIREMENTS

The collection of beneficiary and service utilization data by Medi-Cal Fee-For-Service (FFS) network providers is a mandatory requirement of the LACDMH contract. Federal (*Health Care Financing Administration*), State of California (*Departments of Health Services and Mental Health*), and County (*Department of Mental Health*) all mandate reporting of beneficiary-based information regarding the individuals served by county mental health plans.

All Medi-Cal FFS network providers are required to collect beneficiary-based information and report this data to the *County of Los Angeles Department of Mental Health Local Mental Health Plan* (LMHP) when:

- ◆ Registering a beneficiary
- ◆ Submitting claims

Beneficiary-based registration data will be entered into the *LACDMH's Data Collection and Reporting system* (IS) pursuant to all applicable requirements and procedures.

The Department is currently communicating Integrated System (IS, the current name of the LACDMH's Data Collection and Reporting System) related issues such as system events, system outages, or policy and procedure changes to its providers via LACDMH's Data Collection and Reporting System (IS) Alerts. In order to receive such announcements, you must subscribe to LACDMH's Data Collection and Reporting System Alert. Please do so as soon as possible by going to the following link, <http://dmh.lacounty.gov/hipaa/index.html>, then enter your name and e-mail address, and click on the "submit" button. You will then receive an e-mail asking you to click on a link to confirm your subscription.

Integrated System (IS) Training Manual

IS Training Manual is available and attached at the end of the Provider Manual. The link to the IS System is <https://dmhisintra.co.la.ca.us/Home/Public/Login.aspx>

Open Episode Form and Close Episode Form

For IS Data Entry, the Open Episode Form and the Close Episode Form should be filled out by the clinical staff for the Data Entry staff to input the episode/admission into the IS System. The Open Episode Form and the Close Episode Form should be submitted with the TAR form. The forms are available at the end of this section. The Forms can also be accessed online as follows:

Open Episode Form:

http://dmh.lacounty.gov/hipaa/downloads/OPENINPATIENTEPISODERevised_06062008ET.pdf (attachment I)

Close Episode Form:

http://dmh.lacounty.gov/hipaa/downloads/CLOSE_INPATIENT_EPISODE_Revised06062008ET.pdf (attachment II)

The IS Codes Manual:

There are various codes for the Open/Close Episode forms to be completed. The codes are available in the IS Training Manual. You can also access IS Codes Manual online at http://dmh.lacounty.gov/hipaa/documents/CODESMANUAL-IS2_Version_3.9.pdf

Dual Diagnosis Code Decision Tree

At the end of this section is a copy of the Dual Diagnosis Code Decision Tree (attachment IV) and the Dual Diagnosis Codes (attachment III) for Substance Abuse. The Decision Tree can be used to determine the Dual Diagnosis code to be filled in the form. This code should not be left blank. If there is no use of or history of psychoactive substances that interferes with the mental disorder and adaptive functioning, then “30xNO” should be used.

SECTION: XVII DEFINITIONS, ABBREVIATIONS AND PROGRAM TERMS

GLOSSARY OF TERMS

- **Beneficiary:** The person receiving services; synonymous with consumer, or patient.
- **Chief Information Officer Bureau (CIOB):** The Los Angeles County Department of Mental Health's bureau responsible for maintaining automated data collection and reporting system, i.e., the LACDMH Data Collection and Reporting System.
- **Client Identification Number (CIN):** Medi-Cal beneficiaries are assigned the client identification number by the Department of Public Social Services (DPSS).
- **Integrated System, or Information System; the LACDMH Data Collection and Reporting System, and the LACDMH Information System (IS)** are used interchangeably when referring to the Los Angeles County Department of Mental Health's (LACDMH) computer system storing all client and program service information pertinent to all facets of its services and operations. All patient information stored into the LACDMH Data System and Reporting System must be in strict compliance with rules, procedures and protocols promulgated by the LACDMH's Chief Office of Information Bureau in order to protect patient confidentiality and in compliance with all Federal, State, County and professional regulations, rules, procedures and protocols.
- **Local Mental Health Plan (LMHP):** Agency designated by the State Department of Mental Health (SDMH) responsible for implementation and management of the Medi-Cal Consolidation Program, e.g., Los Angeles County Department of Mental Health (LACDMH)..
- **Medicare:** A Federal Health Insurance Program for people who have attained the age of 65 or over, or have received SSD for two years or more.
- **NPI:** National Provider Identifier
- **EDS TAR Master File:** Electronic data file maintained by SDMH's fiscal intermediary recording all relevant TAR information, e.g., beneficiary identification, dates of service, number of days approved for reimbursement, etc.
- **TAR Update Transmittal (TUT):** Form completed and submitted by the LMHP to correct information recorded on the EDS TAR Master File.
- **Single Point of Contact (SPOC):** See Section III

SECTION: XVIII FREQUENTLY ASKED QUESTIONS

Q&A

- What is the address, telephone and fax numbers for the Los Angeles County Department of Mental Health's Treatment Authorization Unit? **The TAR Unit contact information is as follows:**

**550 S. Vermont Avenue, Room 701
Los Angeles, California 90020
Tel: (213) 739-7300
Fax: (213) 487-7483/ (213) 427-6164
Email: TARUnit@dmh.lacounty.gov**

- How does a provider get information about a specific TAR? **Any inquiry regarding a specific TAR must be submitted only by the provider's designated Single Point of Contact (SPOC) in writing; then mailed, delivered or faxed to the TAR Unit.**
- How does a provider change their designated Single Point of Contact (SPOC)? **At any time, and as often as necessary, a provider may change their SPOC by submitting a written notification to the TAR Unit on the provider's letterhead stationary, providing the name, mailing address, telephone and fax number of their SPOC. Please allow at least one (1) business day for the TAR Unit to update their files.**
- Where can someone get information about mental health outpatient and inpatient services in Los Angeles County? **Phone the Los Angeles County Department of Mental Health ACCESS Center Hotline at (800) 854-7771. The ACCESS Center is staffed 7-days a week-24hours per day.**
- Does the Local Mental Health Plan (LMHP), i.e., the Los Angeles County Department of Mental Health (LACDMH), arrange and reimburse for transporting (e.g., via ambulance) a Medi-Cal beneficiary? **No.**
- What can be done about a TAR not included in the EDS TAR Master File? **Refer to Section X, page 1-1.**
- What can be done to correct erroneous TAR information on the EDS TAR Master File? **Refer to Section X, page 1-1.**
- Where do providers get TAR (SDMH 18-3 3/07) forms? **SDMH fiscal intermediary, i.e., Electronic Data Systems (EDS), provides Mental Health Stay in a Hospital TAR forms. Each TAR is uniquely numbered and must not be duplicated. Copies of TARs cannot be processed by the TAR Unit. Request Mental Health Stay in a Hospital TAR forms by telephoning EDS at (800) 541-5555.**
- What is the SDMH website for Medi-Cal provider enrollment information and application forms? **SDMH's website for provider enrollment information and application forms is www.medi-cal.ca.gov.**

SECTION: XIX IMPORTANT TELEPHONE NUMBERS

IMPORTANT PHONE NUMBERS

Treatment Authorization Unit	LACDMH	(213) 739-7300 (Voice) (213) 487-7483 (Fax) (213) 427-6164 (Fax)
1 st Level TAR Appeals Section	LACDMH	(213) 739-7300 (213) 639-6344
2nd Level TAR Appeals	State DMH	(916) 651-3838 Fax (916) 651-3921
EDS Medi-Cal Processing Service Center	State DMH	(800) 541-5555
California State Dept. of Mental Health	State DMH	(916) 651-9370
Access Center	LACDMH	(800) 854-7771
Patient's Rights Bureau	LACDMH	(213) 738-4673
Lanterman-Petris-Short (LPS) Designation Coordinator	LACDMH	(213) 639-6315
Contract Development and Administration Division	LACDMH	(213) 738-4684
Chief Information Office Bureau Helpdesk	LACDMH	(213) 351-1335

SECTION: XX

ALERTS



Provider Alert



FEBRUARY 10, 2012

Alert No: 2012- 01

FFS Medi-Cal Inpatient Hospital

A Publication of the Local Mental Health Plan (LMPH) of the County of Los Angeles Department of Mental Health

IN THIS ISSUE

• **Administrative Day**

This Provider Alert is being sent to notify Fee-For-Service Hospital Providers regarding changes in the language and documentation requirements of the current Administrative Day Inpatient Hospital Services policy found in Section VII, pages 5-7 of the Medi-Cal Fee-For Service Inpatient Hospital Provider Manual. The Administrative Day Policy was amended to conform to the language stated in California Code of Regulations, Title 9, Chapter 11, Sections 1810.202 and 1820.220.

Per Title 9, “Administrative Day Service” means *psychiatric inpatient hospital services provided to a beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the beneficiary’s stay at the hospital must be continued beyond the beneficiary’s need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options at non-acute residential treatment facilities that meet the needs of the beneficiary.*

Effective May 1, 2012, all documentation submitted to the Treatment Authorization Request (TAR) Unit as a basis for consideration for approval for Administrative Days shall include but not limited to the following criteria:

1. Facilities that are being considered as placement options for lower level of care shall have a treatment component. Facilities that offer solely drug and alcohol program component will not be accepted. Board and Care facilities without treatment programs will not be accepted. A Board and Care facility may have a license to operate but may not have a treatment component included in their program.
2. If there are no appropriate non-acute treatment facilities available and the facility has documented only the minimum number of appropriate contacts (no less than one per week), there must be a justification in the medical record why there are less than five contacts made.
3. The status of the contact must be documented. “Faxed an application packet” or “pending” will not be accepted as status of contact. There must be further follow up documentation by the staff who is involved in the placement process during the identified week. For review purposes, “week” starts on the day that administrative day was ordered. Please follow the contact requirements identified in the new Administrative Day Policy.

- 4. For beneficiaries who need long-term residential placement, please follow the process identified in the policy.

If you have any questions regarding this policy or are in need of training or assistance, please contact my staff, Julie Agojo, R.N., at (213) 739-7300.



Pansy Washington, M.S.
 Mental Health Clinical District Chief
 Managed Care Division
 Office of the Medical director

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Provider Alert



OCTOBER 2011, Second Edition, Alert No: 2011-01

FFS Medi-Cal Inpatient Hospital

A Publication of the Local Mental Health Plan (LMHP) of the County of Los Angeles Department of Mental Health

IN THIS ISSUE

- Provider Manual
- Integrated System (IS) Application Forms
- E-TAR Inquiry, TUT and Resubmit

Provider Manual

The Local Mental Health Plan (LMHP) requires providers to access and comply with the guidelines identified in the Medi-Cal Fee-for Service Provider Manual. This Manual is an extension of the Mental Health Services Contract Agreement. To access the Provider Manual, please go to the following link.

http://dmh.lacounty.gov/ToolsForAdministrators/Agency_Administration/documents/Provider%20and%20IS%20Manual%202010.pdf

The Provider Manual provides comprehensive instructions and information regarding LMHP provider requirements including but not limited to the following:

LAC-DMH Contract (Section II)	Inquiry, TUT and Resubmit(Section X)
Single Point of Contact (SPOC) (Section III)	Medical Necessity Criteria (Section XI)
TAR Process Flow Chart (Section IV)	Notice of Action (Section XII)
Timelines (Section V)	Resource Information (Section XIII)
Instructions for completing TAR (Section VI)	Provider Site Review (Section XIV)
Submission of a TAR (Section VII)	Data Collection & Reporting System Requirements (XVI)
Appeals (Section VIII)	Definition, Abbreviations and Program Terms (Section XVII)
Compliance (Section IX)	

Please contact the contract liaison at (213) 739-7303 if you need to schedule the orientation/training for your clinical and administrative staff.

Integrated System (IS) Application Forms:

Application forms must be completed to initiate providers' access to the Integrated System (IS), the Department's billing system. A set of required forms are included in this package. Additional forms may be

retrieved from the IS. To access the IS, go to the Department's website address: <http://dmh.lacounty.gov/>. Highlight "Administrative Tools for Providers" and select "Integrated System." Click "Outpatient Fee-For-Service" and click the "IS Forms" link. From this screen, you may proceed to download and complete the following required forms:

1) Application Access Form, Codes and Roles:

Form: http://dmh.lacounty.gov/hipaa/downloads/AAF_cl.pdf,

Sample Form: <http://dmh.lacounty.gov/hipaa/downloads/FFSAAFSAMPLE1.pdf>

Instruction: <http://dmh.lacounty.gov/hipaa/downloads/ApplicationAccessFormInstructionsManual.pdf>

Codes: <http://dmh.lacounty.gov/hipaa/downloads/ApplicationAccessFormCodes.xls>

Roles: <http://dmh.lacounty.gov/hipaa/downloads/IntegratedSystemAccessRoles.pdf>

2) Authorization to Sign CIOB Access Forms:

Form: <http://dmh.lacounty.gov/hipaa/documents/Auth%20Sign%20CIOB%20Revised.pdf>

Sample Form: <http://dmh.lacounty.gov/hipaa/documents/Auth%20Sign%20CIOB%20Sample.pdf>

3) Confidentiality Oath Form: <http://dmh.lacounty.gov/hipaa/downloads/ConfidentialityOath2.pdf>

4) Downey Data Center Registration and Agreement for Acceptable Use Forms:

Form: <http://dmh.lacounty.gov/hipaa/documents/DDCR%20Revised%20Form%20-%20Contractor.pdf>

Sample Form: http://dmh.lacounty.gov/hipaa/documents/DDCR%20Revised%20Form%20-%20Contractor_sample.pdf

Mail completed forms to the address indicated on the form. Approximately three to four weeks from the date the Department receives the forms, an RSA Secure ID Token or Card will be mailed to your attention.

E-TAR Inquiry, TUT and Resubmit

All requests regarding TARs, including inquiries, resubmissions or TAR Update Transmittal (TUTs), must be submitted in writing and mailed or faxed to the TAR Unit Inquiry Desk. Telephone inquiries are not acceptable. Always include a copy of the TAR (s) and e-TAR inquiry in question.

Send to the Inquiry, Correction and Resubmit desk any of the following requests:

- Status of a TAR
- Requests for a TAR Update Transmittal (TUT). TUTS are used to correct errors on TARs already on the Master File.
- Request for resubmission of a TAR to EDS.

A response from LACDMH TAR Unit can be expected within 4 weeks of receipt.

If there are any questions regarding this letter, please contact Ms. Myeisha Williams at (213) 738-4923.